

MARYLAND

3192

03146

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Willards</u> LENGTH OF STAY (in this place) <u>25 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Willards</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mary Ethel</u> (First) <u>Adkins</u> (Middle) (Last)		4. DATE OF DEATH <u>March 24</u> (Month) (Day) (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 24, 1904</u> (Month) (Day) (Year) <u>50</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
10. FATHER'S NAME <u>William Leonard Gorman</u>		11. BIRTHPLACE (State or foreign country) <u>Whaleyville</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES (If year, give year or dates of service) <u>No</u>		13. CITIZEN OF WHAT COUNTRY <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Sadie Bell Truett</u>		15. INFORMANT AND ADDRESS <u>Mrs Sadie Gorman Willards Md.</u>	
16. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>12 hrs</u>
Antecedent cause(s) (b) <u>Hypertension - arteries sclerotic</u>			<u>5 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE OF HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1</u> , 1953, to <u>March 24</u> , 1955, that I last saw the deceased alive on <u>March 24</u> , 1955, and that death occurred at <u>5:45 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frank P. Lewis M.D.</u> (Degree or title)		ADDRESS <u>Willards Maryland</u> DATE SIGNED <u>3-25-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3/28/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Willards</u>		LOCATION (City, town, or county) (State) <u>Willards, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3-29-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
24. FUNERAL DIRECTOR <u>Peter Whaley</u>		ADDRESS <u>Whaleyville Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED  
APR 1 1955  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3193

03147

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Near Delmar</u>				<input checked="" type="checkbox"/> TOWN <u>Parsonsburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>On Highway</u>				STREET ADDRESS (If rural, give location) <u>R.D. # 2</u>			
3. NAME OF DECEASED: (First) <u>MARY</u>		(Middle) <u>ELLEN</u>		(Last) <u>BAKER</u>		4. DATE OF DEATH (Month) <u>MAR</u> (Day) <u>17</u> (Year) <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Baby</u>	8. DATE OF BIRTH: <u>July 1, 1954</u>		9. AGE last birthday: <u>0</u> yrs.		IF UNDER 1 YEAR <u>8</u> Months <u>18</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Ocean City Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Elijah Archie Baker</u>				14. MOTHER'S MAIDEN NAME: <u>Heater Elizabeth Webb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mr &amp; Mrs. Elijah A. Baker (Father &amp; Mother)</u>			
18. MEDICAL CERTIFICATION R.D. # 2 Parsonsburg, Md.				INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>491X</u> Immediate cause (a) <u>Broncho pneumonia</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>9</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Emil H. Royce</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Mar. 18 1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 19, 1955</u>		<u>Line Church Cemetery</u>		<u>Near Pittsville, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>4/13/55</u>		REGISTRAR'S SIGNATURE <u>Harry C. Hudson</u>		24. FUNERAL DIRECTOR ADDRESS <u>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</u>			

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BUREAU V. S.

MAR 23 1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3194

03148

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>Salisbury</u>		<u>50 Yrs.</u>		<u>Salisbury</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u> Rt #1				<u>Rt #1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>MARY</u> (First) <u>ESTHER</u> (Middle) <u>BANKS</u> (Last)				<u>3</u> <u>15</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>July 11, 1862</u>	<u>92</u> Yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>T.W.H. White Sr.</u>				<u>Louisa Fooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mr. Austin Banks, Same</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>782.4</u> IMMEDIATE CAUSE (A) <u>Cardiac - Old Age</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Died in sleep</u>							
DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>1944</u> , to <u>Mar 15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 55</u> , 19 <u>55</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>William D. Gray, M.D.</u>				DATE SIGNED <u>3/17/55</u>			
ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/17/55</u>		<u>White Cemetery</u>		<u>Shad Point, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>3/18/55</u>		<u>A. W. Sedgwick</u>		<u>George C. Hill II</u>		<u>The Hill &amp; Johnson Co. Salisbury, Md.</u>	

# CERTIFICATE OF DEATH

101

BUREAU V. 51

1955

RECEIVED

PHOTOCOPYED  
 This is a photocopy of a document from the Wyoming State Department of Health - Division of Vital Records. The original document is a Certificate of Death, Form 101, dated 1955. The document is a form used to record the death of a person in Wyoming. It contains fields for the decedent's name, date of birth, date of death, place of death, cause of death, and other information. The document is a form used to record the death of a person in Wyoming. It contains fields for the decedent's name, date of birth, date of death, place of death, cause of death, and other information.

NAME OF DECEASED _____	
SEX _____	AGE _____
DATE OF BIRTH _____	DATE OF DEATH _____
PLACE OF BIRTH _____	PLACE OF DEATH _____
CAUSE OF DEATH _____	
MANNER OF DEATH _____	
SIGNATURE OF DECEASED _____	
SIGNATURE OF WITNESS _____	
SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CLERK _____	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3195

CERTIFICATE OF DEATH

Reg. Dist. No. 03149 336

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MARLBOROUGH</u>			
X TOWN <u>MARLBOROUGH</u>		<u>9 mo</u>		STREET ADDRESS (If rural give location) <u>BRIDGE ST</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 MARLBOROUGH SHADE NURSING HOME</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>CRAWFORD TRA BENNETT</u>				OF DEATH: <u>3</u> <u>26</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>DEC 10, 1885</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FARMER</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>	11. BIRTHPLACE (State or foreign country): <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>GEORGE BENNETT</u>				14. MOTHER'S MAIDEN NAME: <u>JENNY RUSSELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT & ADDRESS: <u>MRS CRAWFORD BENNETT</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>446X</u> <u>uremia; arteriosclerotic nephritis</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>arteriosclerosis</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypostatic pneumonia</u>							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/2</u> , 19 <u>55</u> to <u>death</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. Lamm</u>		M. D. <u>Delmar, Del</u>		DATE SIGNED <u>3/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>MARLBOROUGH</u>		LOCATION (City, town, or county) (State) <u>MARLBOROUGH SPRINGS, MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/29/55</u>		REGISTRAR'S SIGNATURE <u>Mary C Ovens</u>		24. FUNERAL DIRECTOR ADDRESS <u>Paul G. Smith, Jr., Baltimore, Md.</u>			



BUREAU V. S.

APR 1 1955

RECEIVED



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## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03150

3160

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>15 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 25,</u>		<u>02X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91 Deer's Head State Hospital</u>		STREET ADDRESS (If rural give location) <u>109 2nd. Ave.</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Frederick</u> (First) <u>Boesch</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Mar. 11</u> <u>1955</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>wid.</u>	<b>8. DATE OF BIRTH</b> <u>Oct. 14, 1881</u>	<b>9. AGE last birthday</b> <u>73</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>-</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>---</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>---</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>unk</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>unk</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>199.8 IMMEDIATE CAUSE</b> (A) <u>Pulmonary edema</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 hrs.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Acute myocardial insufficiency</u>						<u>24 hrs.</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Pulmonary bronchogenic Ca. and Ca. of tongue</u>						<u>?</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arteriosclerosis - general</u>						<u>?</u>	
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>2/24</u> , 19 <u>55</u> , to <u>3/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/11</u> , 19 <u>55</u> , and that death occurred at <u>3:15 P.</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Dr. V. Juernuan</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Deer's Head State Hospital; Salisbury, Md.</u>		<b>DATE SIGNED</b> <u>3/11/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3/15/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cem</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Balto Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Mar. 14, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rott C. B. Walters</u>		<b>ADDRESS</b> <u>Street</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03151  
3196 CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town)			
TOWN <u>SHARPTOWN</u>		<u>254RS</u>		TOWN <u>SHARPTOWN</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. FERRY ST</u>				STREET ADDRESS (If rural give location) <u>N. FERRY ST</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>JOHN ELMER BOWMAN</u>				<u>MAR 16 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>FEB 23 1873</u>	
				9. AGE last birthday: <u>82</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>BOOKERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>ANDREW BOWMAN</u>				14. MOTHER'S MAIDEN NAME: <u>ELLA LOWE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No.: <u>218-805313</u>			
				17. INFORMANT & ADDRESS: <u>Mrs JOHN ESKRIDGE</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause <u>420.1</u> (a) <u>Cerebral Occlusion</u>						<u>3 hrs.</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerosis</u>						<u>16 years</u>	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cardiac Vascular Disease</u>							
19a. DATE OF OPERATION: <u>0</u> 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 16 1955</u> to <u>Mar 16 1955</u> , that I last saw the deceased alive on <u>Mar 15 1955</u> , and that death occurred at <u>3 94</u> from the causes and on the date stated above.							
SIGNATURE <u>M. S. Ruhman</u>		(Degree or title)		ADDRESS <u>Sharptown MD</u>		DATE SIGNED <u>3/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAR 20 1955</u>		<u>FIREMENS</u>		<u>SHARPTOWN MD</u>	
DATE RECD BY LOCAL REGISTRAR <u>March 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary C. Owens</u>		24. FUNERAL DIRECTOR <u>Paul J. Smith</u>		ADDRESS <u>Sharptown MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

21 MAR 1955

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BUREAU V. 1

MAR 23 1955

RECEIVED

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3161

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL or and give nearest town)			
12 TOWN <u>Salisbury</u>		3 days		OR TOWN <u>Pocomoke</u>		23-42-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
87 <u>Peninsula General Hosp.</u>				703 Cedar St. ✓			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH:			
<u>John W. Bundick</u>				<u>3 30 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Dec. 2, 1877</u>		<u>77</u> yrs.	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Retired Farm Owner</u>						<u>Virginia</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John W. Bundick, Sr.</u>				<u>Emma Shreaves</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>90</u> ✓				<u>✓</u>		<u>Mrs Virginia Bundick, Pocomoke Md</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
199.9							
IMMEDIATE CAUSE (A) <u>Carcinoma metastases, unknown</u>							
DUE TO							
ANTECEDENT CAUSE (B)							
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>generalized arteriosclerosis</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY?							
YES <input type="checkbox"/>				NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-27</u> , 19 <u>55</u> , to <u>3-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-30</u> , 19 <u>55</u> , and that death occurred at <u>7p</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>William R. Ellis, Jr.</u>				<u>Salisbury, Md</u>		<u>3-30-55</u>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>4-1-55</u>		<u>Bethany, Md. Cemetery</u>		<u>Pocomoke, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-5-55</u>		<u>Mary W. Holloman</u>		<u>Watson - Pocomoke</u>		<u>Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 4 1955  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. ROYER - Camden Ave - Salisbury Md.

03153

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>DELAWARE</u>	COUNTY <u>Sussex</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Laurel</u>	<u>46X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>		STREET ADDRESS (If rural, give location) <u>R. D. # 2</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>J.</u>	(Middle) <u>Leeman</u>	(Last) <u>Callaway</u>	(Month) <u>MAR</u> (Day) <u>5th</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Oct. 10 - 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>FARMING - ON FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>48</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>LA Fayette Callaway</u>		14. MOTHER'S MAIDEN NAME: <u>Starric - unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>MRS. Edna Records - Laurel, Del.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
910.1 Immediate cause (a) <u>Lower nephron nephrosis</u>	DUE TO	<u>2 days</u>
Antecedent cause(s) (b) <u>multiple fractures pelvis</u>	DUE TO	<u>5 days</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>gunshot left leg</u>		<u>+ days</u>
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <u>2-28-55</u>		19b. MAJOR FINDING OF OPERATION: <u>Ruptured aortic aneurysm - Ruptured 2 line vessel left</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Farm</u> )	21c. City or town) <u>Laurel</u>	(County) <u>Sussex</u>	(State) <u>Delaware</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2 28 55 8 AM</u>	21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Chicken coop fell on him</u>		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl L. Royer CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 3-6-55  
DEPUTY MEDICAL EXAMINER ☐  
M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF: <u>3-7-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Odd Fellow Cemetery</u>	LOCATION (City, town, or county) (State): <u>Laurel, Delaware</u>
DATE REC'D BY LOCAL REG. <u>3-7-55</u>	REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR: <u>Windsor &amp; Disharoon Fun. Home</u>	ADDRESS: <u>Laurel, Delaware</u>

RECEIVED MAR 10 1955

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]

Reference is made to [Illegible]

[Illegible]

BUREAU V. S.

MAR 9 1955

RECEIVED

3163

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND COUNTY Somerset</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		19X-2	
12 TOWN <u>SALISBURY</u>				PRINCESS ANNE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>PENINSULA GENERAL HOSPITAL</u>				<u>R. R.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)				
(Type or Print) <u>Shirley</u>			OF DEATH: <u>MARCH 19 1955</u>				
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>MALE</u>		<u>white</u>				<u>Jan. 26, 1880</u>	
						9. AGE last birthday <u>75</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Retired Farmer</u>				<u>Prince George Co., Va</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>George W. Clark</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>g</u>						<u>William S. Clark, Balto., Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Alveolar W. str</u>							<u>3 Yr off</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Extensive To Liver &amp; Brain</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>March 18, 1955</u>			<u>Alone</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		
					INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>3-2</u> , 19 <u>55</u> , to <u>3-19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-19</u> , 19 <u>55</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>John M. B. Holman Jr.</u>				<u>M. D. Salisbury, Md.</u>		<u>March 20, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>3-22-55</u>		<u>3-22-55</u>		<u>Perryhawkins Cemetery</u>		<u>E. Princess Anne, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-22-55</u>		<u>Mary W. Holloman</u>		<u>James R. Hunman</u>		<u>Princess Anne, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 24 1955

RECEIVED

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INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3197

## CERTIFICATE OF DEATH

03156

332

Reg. Dist. No. ....

DR. QUINN

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Mardela</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Mardela</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Railroad Ave.</u>				STREET ADDRESS (If rural give location) <u>Railroad Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARION</u> (Middle) <u>JAMES</u> (Last) <u>CORDREY</u>				(Month) <u>March</u> (Day) <u>11</u> (Year) <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16, 1890</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months <u>8</u> Days <u>25</u>		Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee of Phillips Packing Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>R.D. Hebron, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Cordrey</u>				14. MOTHER'S MAIDEN NAME <u>Janie Henderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Daisey Cordrey (Wife) Railroad Ave.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>Mardela, Maryland</u>			
4444 IMMEDIATE CAUSE (A) <u>High B. P. diet not healthy</u>				<u>Short</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>not known</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>not known</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 11, 1955</u> , to <u>March 11, 1955</u> , that I last saw the deceased alive on <u>March 9, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Quinn</u>				ADDRESS (Street, city, town, state) <u>Mardela, Maryland</u> DATE SIGNED <u>March 12, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery (New)</u>		LOCATION (City, town, or county) <u>Mardela, Maryland</u>	
24. REC'D BY REGISTRAR <u>March 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

BUREAU V. S.

MAR 15 1955

RECEIVED



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3164

## CERTIFICATE OF DEATH

03157

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		6 weeks		TOWN <u>St. Michaels</u>		20x-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
MARY JANE DENNIS				March 17 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Colored	Widow	Sept. 1890	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housework		Housework		Talbot County Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joe Miller				Kate Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No 4 (If Yes, give war or dates of service)		-		Hospital Records			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
174x IMMEDIATE CAUSE (A) General Carcinomatosis due to							
ANTECEDENT CAUSE(S) DUE TO (B) Ca. of uterus							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 4, 1955</u> , to <u>Mar. 17, 1955</u> , that I last saw the deceased alive on <u>Mar. 17, 1955</u> , and that death occurred at <u>8:45P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. J. Jerman</u>				ADDRESS (Street, city, town, state) <u>Deer's Head Hospital; Salisbury, Md.</u>		DATE SIGNED <u>3/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/20/55		Sherwood		Sherwood, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3/24/55</u>		<u>Mary Holloway</u>		<u>Norman D. Marshall</u>		<u>St. Michaels, Md.</u>	

MAR 29 1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3165

## CERTIFICATE OF DEATH

03158

332

Dr. Gardner

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>		STREET ADDRESS (If rural give location) <b>313 Penn St</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>HERBERT CLARENCE DERBY</b>				<b>4. DATE OF DEATH</b> <b>March 1 th 19 55</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>June 16, 1886</b>	
<b>9. AGE last birthday</b> <b>68</b> yrs.		<b>10. KIND OF BUSINESS OR INDUSTRY</b> <b>Painter (Contractor) Painting</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>New York State</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Harvey C. Derby</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>J. Ann Austin</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Mabel P. Derby (Wife) 313 Penn St</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>443X</b>				<b>Salisbury, Maryland</b>			
<b>IMMEDIATE CAUSE (A)</b> <b>Cerebrovascular Accident</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>30 days</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<b>Hypertensive Cardio-vascular Disease</b>			
<b>(C)</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>Pneumonia, Bacterial</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 2/26, 1955, to 3/1, 1955, that I last saw the deceased alive on 3/1, 1955, and that death occurred at 10:40 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b> Rufus S. Gardner, Jr.</b>				<b>ADDRESS (Street, city, town, state) DATE SIGNED</b> <b> 321 S. Div. St. Salisbury, Md. March 1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>March 4, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Mar. 3, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			

# CERTIFICATE OF DEATH

1965, Date of Birth

1. NAME AND RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. SEX AND AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

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THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR.

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## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3168

## CERTIFICATE OF DEATH

03160

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place) <u>1 Hour</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>OCEAN CITY</u> <u>23X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS <u>RR 1</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>VIOLET ELLEN DOWNEY</u> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MARCH 15 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAR. 3, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER TOURIST HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK ESHERMAN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>MR. JOHN DOWNEY, BERLIN MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
33IX IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-15</u> , 19 <u>55</u> , to <u>3-15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-15</u> , 19 <u>55</u> , and that death occurred at <u>1:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Lois Ann R. Ellis, Jr.</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>3-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S</u>		LOCATION (City, town, or county) (State) <u>LEMONS PA.</u>	
24. REC'D BY REGISTRAR <u>March 17, 1955 Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>		ADDRESS <u>Berlin Md</u>	



# CERTIFICATE OF DEATH

Reg. Dist. No.

A. REGULAR RESIDENCE (HOME OR GRAVE)

MARRIAGE

B. PLACE OF DEATH

4. DATE

DEATH

5. SECOND

6. THIRD

7. FOURTH

8. FIFTH

9. SIXTH

10. NAME - V. S.

11. NAME - V. S.

12. NAME - V. S.

13. MEDICAL HISTORY

14. CAUSE OF DEATH

15. MANNER OF DEATH

16. PLACE OF DEATH

17. TIME OF DEATH

18. SIGNATURE OF DECEASED

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF CORONER

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF CLERK

25. SIGNATURE OF REGISTRAR

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CONSTABLE

28. SIGNATURE OF JAILER

29. SIGNATURE OF PRISONER

30. SIGNATURE OF GUARD

31. SIGNATURE OF WARDEN

32. SIGNATURE OF CHIEF CLERK

33. SIGNATURE OF DEPUTY CLERK

34. SIGNATURE OF ASSISTANT CLERK

35. SIGNATURE OF RECORDS CLERK

36. SIGNATURE OF FILE CLERK

BUREAU V. S.

MAR 17 1955

RECEIVED

NOTIFICATION

LAURENCE RO. MORTIMER, MORTIMER 07

LAURENCE RO. MORTIMER, MORTIMER 07



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03161

5140

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 3, Film G182 6-15-55 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>50 yrs.</u>		TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		<u>1</u>	
<u>400 Park Ave.</u>				<u>400 Park Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ANNIE</u> (Middle) <u>ELIZABETH</u> (Last) <u>L. DOWNING</u>				(Month) <u>3</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 22, 1860</u>	
9. AGE last birthday <u>94</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John W. Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Ellen L. Searan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. John Downing, 319 Park Ave.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis &amp; Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Aug 3/18</u> , 19 <u>54</u> , to <u>3/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>55</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frederic R. Gramse</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>3/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>MAR 21 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George C. Hill II</u>		ADDRESS <u>The Hill &amp; Johnson Co. Salisbury, Md.</u>	

MAR 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3167

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 02162  
No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Salisbury</u>		<u>life</u>		TOWN <u>Salisbury, Md.</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>621 Lake St.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Herbert</u>		(Middle) <u>Farlow</u>		(Last) <u>1955</u>	
4. DATE OF DEATH		(Month) <u>3</u>		(Day) <u>6</u>		(Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1-22-1880</u>	9. AGE last birthday: <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Moses Farlow</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Clara Corbin, daughter- 516 Rose St. Salisbury</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>8</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Boyer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-9-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>3-9-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Green Acres</u>		LOCATION (City, town, or county) (State): <u>Salisbury Md</u>	
DATE REC'D BY LOCAL REG. <u>3-9-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>Booker M. West</u>		ADDRESS:	

BUREAU V. S.

MAR 14 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3168

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03163

Reg. Dist. No. 232

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>12</u> TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural, give location) <u>106 Truitt St.</u>			
3. NAME OF DECEASED: (First) <u>LESTER</u>		(Middle) <u>FRANCIS</u>		(Last) <u>HASTINGS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAR 25 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 13, 1896</u>		9. AGE last birthday: <u>58</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Trucking Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Parsonsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Joseph Hastings</u>				14. MOTHER'S MAIDEN NAME: <u>Nancy Ellen Gravenor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>214-10-9636</u>		17. INFORMANT & ADDRESS: <u>Mrs. Lillian P. Hastings (Wife) 106 Truitt St. Salisbury, Maryland</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>Mar. 25, 1955</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Walter R. Holloway</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Mar. 25 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Mar. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsonsburg, ve Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parsonsburg, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3-28-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

Walter R. Holloway

BUREAU V. B.

MAR 30 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03164

3169

## CERTIFICATE OF DEATH

Reg. Dist. No. 832

Item 9, Film 6178 3-15-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 TOWN SALISBURY</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Upper Fairmount 19X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>GROVER</u> <u>HOLLAND</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MARCH 3 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>Sept 5, 1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u>		10B. KIND OF BUSINESS, OR INDUSTRY: <u>Transportation</u>		11. BIRTHPLACE (State or foreign country): <u>Fairmount, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas Holland</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Emily Beauchamp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>3 No</u>		16. SOCIAL SECURITY NO. <u>213-22-6866</u>		17. INFORMANT & ADDRESS: <u>Mrs. Irene Holland, Upper Fairmount, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>24 hrs</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>						<u>Symptoms 1 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Myocardial Insufficiency 3 years</u> <u>Arteriosclerotic Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-3-1955</u> , to <u>3-3-1955</u> , that I last saw the deceased alive on <u>3-3-1955</u> , and that death occurred at <u>7:23 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward J. Schum</u>				M. D. <u>Salisbury Md.</u>		DATE SIGNED <u>Mar. 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>3-6-55</u>		<u>Muir's Family Cemetery</u>		<u>Upper Fairmount, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-4-55</u>		<u>Mary W. Holloway</u>		<u>Harry B. Miles, Upper Fairmount, Md</u>			

BUREAU V. S.

MAR 7 1955

RECEIVED

3170

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Salisbury</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Princess Anne</i>		19K-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>R. F. D.</i>		✓	
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
DECEASED: <i>Osley D. Howell</i>				OF DEATH: <i>March 5 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <i>Nov. 4, 1869</i>	
9. AGE last birthday <i>85</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, when it related): <i>Retired Building Construction</i>		11. BIRTHPLACE (State or foreign country): <i>Heater, N. Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>George Howell</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Mrs. Josephine Porter Howell</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Central Hemorrhage</i>				8 days			
ANTECEDENT CAUSE (S) (B) <i>Central Arteriosclerosis</i>				Symptoms 2 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <i>Myocardial insufficiency</i>				one year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Auricular Fibrillation</i>							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb. 25, 1955</i> to <i>Mar. 5, 1955</i> , that I last saw the deceased alive on <i>Mar. 4, 1955</i> and that death occurred at <i>9:15 A M.</i> from the causes and on the date stated above.							
SIGNATURE <i>David J. Schorr</i>				ADDRESS <i>Salisbury Md</i>		DATE SIGNED <i>Mar 5 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-8-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Allen Cemetery</i>		LOCATION (City, town, or county) (State) <i>Allen, Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3-8-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. Hollonay</i>		24. FUNERAL DIRECTOR <i>Levin B. Wilson</i>		ADDRESS <i>Princess Anne, Md</i>	

MARGIN RESERVED FOR BINDING

RECEIVED  
MAR 14 1955  
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3198

03166

Reg. Dist. No. 332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Wettpquin</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Wettpquin</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>							
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Albert</u>		(Middle) <u>Hill</u>		(Last)		(Month) (Day) (Year) <u>3 6 19 55</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Single</u>		<u>12-1922</u>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>33</u> yrs.		<u>none</u>		<u>Wettpquin</u>		<u>U.S.A</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Rogers Hall</u>				<u>Pauline Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>11-11-55</u>				<u>216-18-8225</u>		<u>Rogers Hall</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Carbon-monoxide poisoning</u>						<u>Sudden</u>	
DUE TO							
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>0</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg, etc., INJURY)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>Primary</u>		<u>Street</u>		<u>Sandy Hill Wicomico Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3 6 55 2</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>House fire exploded into closed car.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Rogers</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-11-55</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-13-55</u>		<u>Family Cem.</u>		<u>Wettpquin Md.</u>	
DATE RECD BY LOCAL REG. <u>3-11-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hallomay</u>		24. FUNERAL DIRECTOR <u>Locher W. Quack</u>		ADDRESS	

RECEIVED

MAR 14 1955

BUREAU V. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3171

## CERTIFICATE OF DEATH

03167

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>12</u> <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82</u> <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u> <u>515 East William St</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>JUNE</u> <u>EARLINE</u> <u>HUMPHREYS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MAR</u> <u>31</u> <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Baby</u>	8. DATE OF BIRTH <u>Nov. 17, 1954</u>	9. AGE last birthday <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pen. Gen. Hospital Sal. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Humphreys</u>				14. MOTHER'S MAIDEN NAME <u>Frances Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. George W. Humphreys (Father) 515 E.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b> <u>William St Salisbury, Md</u> INTERVAL BETWEEN ONSET AND DEATH <u>2-8 days</u>			
<u>571.0</u> IMMEDIATE CAUSE (A) <u>Hemorrhages massive, Cerebral and gastrointestinal</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cause undetermined</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 30, 19 55</u> , to <u>March 31, 19 55</u> , that I last saw the deceased alive on <u>March 31, 19 55</u> , and that death occurred at <u>12:25 P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Sandoz</u>				DATE SIGNED <u>Apr. 2 55</u>			
M.D. <u>N. Division St Salisbury, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>4/4/55</u>		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u> <u>Walter R. Holloway</u>			

20X417/301

# CERTIFICATE OF DEATH

1935

1. NAME OF DECEASED

2. PLACE OF DEATH

BALTIMORE

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF CLERK

17. SIGNATURE OF ASSISTANT CLERK

18. SIGNATURE OF RECEPTIONIST

19. SIGNATURE OF TELEPHONE OPERATOR

20. SIGNATURE OF MAIL ROOM

21. SIGNATURE OF RECORDS SECTION

22. SIGNATURE OF STATISTICS SECTION

23. SIGNATURE OF LABORATORY

24. SIGNATURE OF X-RAY DEPARTMENT

25. SIGNATURE OF RADIOLOGY DEPARTMENT

26. SIGNATURE OF PATHOLOGY DEPARTMENT

27. SIGNATURE OF BACTERIOLOGY DEPARTMENT

28. SIGNATURE OF VIROLOGY DEPARTMENT

29. SIGNATURE OF IMMUNOLOGY DEPARTMENT

30. SIGNATURE OF EPIDEMIOLOGY DEPARTMENT

31. SIGNATURE OF PUBLIC HEALTH DEPARTMENT

32. SIGNATURE OF HEALTH EDUCATION DEPARTMENT

33. SIGNATURE OF COMMUNITY HEALTH DEPARTMENT

34. SIGNATURE OF SCHOOL HEALTH DEPARTMENT

35. SIGNATURE OF NURSING DEPARTMENT

BUREAU V. S.

APR 7 1935

RECEIVED

SHORT-LETTER

1. NAME OF DECEASED  
2. PLACE OF DEATH  
3. SEX  
4. AGE  
5. OCCUPATION  
6. CAUSE OF DEATH  
7. DATE OF DEATH  
8. TIME OF DEATH  
9. SIGNATURE OF PHYSICIAN  
10. SIGNATURE OF REGISTRAR  
11. SIGNATURE OF WITNESSES  
12. SIGNATURE OF DECEASED  
13. SIGNATURE OF NEXT OF KIN  
14. SIGNATURE OF BURIAL OFFICIAL  
15. SIGNATURE OF INTERVIEWER  
16. SIGNATURE OF CLERK  
17. SIGNATURE OF ASSISTANT CLERK  
18. SIGNATURE OF RECEPTIONIST  
19. SIGNATURE OF TELEPHONE OPERATOR  
20. SIGNATURE OF MAIL ROOM  
21. SIGNATURE OF RECORDS SECTION  
22. SIGNATURE OF STATISTICS SECTION  
23. SIGNATURE OF LABORATORY  
24. SIGNATURE OF X-RAY DEPARTMENT  
25. SIGNATURE OF RADIOLOGY DEPARTMENT  
26. SIGNATURE OF PATHOLOGY DEPARTMENT  
27. SIGNATURE OF BACTERIOLOGY DEPARTMENT  
28. SIGNATURE OF VIROLOGY DEPARTMENT  
29. SIGNATURE OF IMMUNOLOGY DEPARTMENT  
30. SIGNATURE OF EPIDEMIOLOGY DEPARTMENT  
31. SIGNATURE OF PUBLIC HEALTH DEPARTMENT  
32. SIGNATURE OF HEALTH EDUCATION DEPARTMENT  
33. SIGNATURE OF COMMUNITY HEALTH DEPARTMENT  
34. SIGNATURE OF SCHOOL HEALTH DEPARTMENT  
35. SIGNATURE OF NURSING DEPARTMENT

1

## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3172

## CERTIFICATE OF DEATH

03168

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>8 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>300 Pine Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Asa</u> <u>Everett</u> <u>Kniceley</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Mar. 15</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 9, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Methodist</u>		11. BIRTHPLACE (State or foreign country) <u>Braxton County, W.Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Kniceley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Hinkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. # 1 228-05-6470</u>		17. INFORMANT & ADDRESS <u>Janet G. Kniceley, Seaford, Del.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
153X IMMEDIATE CAUSE (A) DUE TO				Interval between ONSET AND DEATH <u>24 hrs</u>			
ANTECEDENT CAUSE(S) (B) DUE TO				<u>Carcinoma of rectum</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) DUE TO							
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>3-14-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of rectum: large distal lobes in situ</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>							
SIGNATURE <u>William H. Fisher</u> M.D.				ADDRESS (Street, city, town, state) <u>Seaford</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-18-1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johnstown</u>		LOCATION (City, town, or county) (State) <u>Greenwood, Del.</u>	
24. REC'D BY REGISTRAR DATE <u>March 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel</u>		ADDRESS <u>Seaford, Del.</u>	

# CERTIFICATE OF DEATH

Form 10-1-1955

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF CEMETERY

17. SIGNATURE OF CHURCH

18. SIGNATURE OF MINISTRY

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

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59. SIGNATURE OF OTHER

BUREAU V. S.

MAR 17 1955

RECEIVED

3-16-1955

ST. JOHNS HOSPITAL

ST. JOHNS HOSPITAL

ST. JOHNS HOSPITAL

1

## INSTRUCTIONS

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VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3173

03169

## CERTIFICATE OF DEATH

Item 9, Filmgl79 3-31-55 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Whaleyville</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>RT. #1</u> ✓			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ELLA M Lewis</u>				<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 7, 1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Madge Atkins, Bishop Ind.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Atherosclerosis</u>				<u>Not known</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21a. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 13, 1955</u> to <u>March 18, 1955</u> that I last saw the deceased alive on <u>March 18, 1955</u> , and that death occurred at <u>6:10 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>David J. Schwan</u>		M.D.		ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>March 18 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>3-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hamblin Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Whaleyville, Md.</u>	
24. REC'D BY REGISTRAR <u>3-19-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Beomoke, Ind.</u>	



# CERTIFICATE OF DEATH

8178

Page One

1. USUAL RESIDENCE OF DECEASED

MARYLAND

PLACE OF DEATH

5112644

5112644

DATE OF DEATH

1955

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BUREAU VI 8

MAR 24 1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

3174

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

03170

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>8 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SHARPTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PINE BLUFF STATE HOSP.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles Jefferson Marine</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 20, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>September 23, 1875</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Laborer (Basket Factory)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Galestown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES MARINE</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
002X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> et work <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MARCH 7, 1947</u> to <u>MARCH 20, 1955</u> , that I last saw the deceased alive on <u>MARCH 20, 1955</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE THEREOF <u>MAR 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>FIREMENS</u>		LOCATION (City, town, or county) (State) <u>SHARPTOWN MD</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>FIREMENS</u>		LOCATION (City, town, or county) (State) <u>SHARPTOWN MD</u>	
24. REC'D BY REGISTRAR DATE <u>3/21/55</u>		REGISTRAR'S SIGNATURE <u>Mary Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul J. Smith</u>		ADDRESS <u>Sharptown, MD</u>	

CERTIFICATE OF DEATH

NAME: *James M. [illegible]*  
AGE: *34 years*  
SEX: *Male*  
RACE: *White*  
DATE OF BIRTH: *March 1, 1921*  
PLACE OF BIRTH: *Chicago, Ill.*  
OCCUPATION: *Electrician*  
CAUSE OF DEATH: *Heart disease*  
DATE OF DEATH: *March 1, 1955*  
PLACE OF DEATH: *Home*  
SIGNATURE OF PHYSICIAN: *[illegible]*  
SIGNATURE OF REGISTRAR: *[illegible]*

BUREAU V. S.

MAR 23 1955

RECEIVED

2/2/55  
[illegible handwritten notes]

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 45C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3175

## CERTIFICATE OF DEATH

03171

Reg. Dist. No. 331

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury, Maryland</u>		<u>1 mon. 5 days</u>		TOWN <u>Crisfield Maryland</u>		<u>19-39-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>207 N. Somerset Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Edward</u>		(Middle) <u>W.</u>		(Last) <u>Marsh</u>		(Month) (Day) (Year) <u>Mar. 13 1955</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>M</u>	<u>W</u>	<u>Widowed</u>	<u>Dec. 10, 1867</u>	<u>87</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>unk</u>		<u>unk</u>		<u>Virginia</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John W. Marsh</u>				<u>Margaret Evans</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>unk</u>		<u>unk</u>		<u>Hospital Record</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>1</b> IMMEDIATE CAUSE (A) <u>Cardiac insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u>						<u>unk</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis general</u>						<u>unk</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>0</u>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb. 8, 1955</u>, to <u>Mar. 13, 1955</u>, that I last saw the deceased alive on <u>Mar. 12, 1955</u> and that death occurred at <u>3:35 A.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>H. Hatcher</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Deer's Head State Hospital Salis, Md.</u>			
<b>DATE SIGNED</b> <u>3/13/55</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAR. 16, 1955</u>		<u>ONANCOCK CEMETERY</u>		<u>ONANCOCK, VIRGINIA</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>3-19-55</u>		<u>Mary W. Holloman</u>		<u>Brashaw &amp; Sons - CRISFIELD, MD.</u>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. PLACE OF DEATH		6. CAUSE OF DEATH	
7. MANNER OF DEATH		8. SIGNATURE OF PHYSICIAN		9. SIGNATURE OF REGISTRAR	
10. SIGNATURE OF WITNESSES		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

MAR 21 1955

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*J. H. [Signature]*

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05107

3176

## CERTIFICATE OF DEATH

Dr. Alberta Mattax

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS <u>622 Light St.</u>			
<b>3. NAME OF DECEASED</b> (First) <u>EDWARD</u> (Middle) <u>A.</u> (Last) <u>McCAFFREY</u>				<b>4. DATE OF DEATH</b> (Month) <u>MAR.</u> (Day) <u>27</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 21, 1893</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Swift &amp; Co. City</u>	11. BIRTHPLACE (State or foreign country) <u>Branchdale Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Edward J. McCaffrey</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Marie C. McCaffrey</u> <u>Wife</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b> <u>622 Light St Salisbury, Maryland</u>			
1. IMMEDIATE CAUSE (A) <u>420.0</u> <u>Coronary infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				5 yrs			
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>Mar 27, 1955</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 27, 1955</u> , to <u>Mar 27, 1955</u> , that I last saw the deceased alive on <u>Mar 27, 1955</u> , and that death occurred at <u>3:25 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>Alberta Mattax</u>				ADDRESS (Street, city, town, state) <u>Camden Ave. Salisbury, Maryland</u>		DATE SIGNED <u>Mar 28, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 30, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) <u>Salisbury, Maryland</u> (State)	
24. REC'D BY REGISTRAR <u>May 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> <u>SALISBURY MARYLAND</u>			







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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

3177

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

03172

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Florida</u>		COUNTY <u>Putnam</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>7 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>East Palatka</u>		<u>48X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>600 W. Isabella Street</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Henry</u> (Middle) <u>Jeremiah</u> (Last) <u>McCoy</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 - 26 - 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>A. A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-8-1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jerry McCoy</u>				14. MOTHER'S MAIDEN NAME <u>Harriett McCoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>267-16-0391</u>		17. INFORMANT & ADDRESS <u>242 Wiley Ave.</u> <u>Mrs. Fannie McCoy Mack, Whitesboro, N.J.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>acute 20</u>	
592X IMMEDIATE CAUSE (A) <u>Acute Uremia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic interstitial Nephritis</u>						<u>March 24/55</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 20, 19 54</u> , to <u>March 26, 19 55</u> , that I last saw the deceased alive on <u>March 26, 19 55</u> , and that death occurred at <u>1:42 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>M.D. Arthur S. Browne M.D. Salisbury - Md</u>		<u>Mar. 26 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Whitesboro Cemetery</u>		LOCATION (City, town, or county) (State) <u>Whitesboro, New Jersey</u>	
24. REC'D BY REGISTRAR DATE <u>3/29/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u> <u>324 E. Church St. Salisbury, Md.</u>			

# CERTIFICATE OF DEATH

Local Health Officer

DEPARTMENT OF HEALTH - BALTIMORE

State of Maryland

West Baltimore

Female

Age 55 - 50 - 55

Male

Age 77 - 72 - 82

Age 77 - 72 - 82

USA

California, North Carolina

Harriet, Mary

Jerry, Mary

1111 11th Ave.  
Baltimore, Md.

1111 11th Ave.  
Baltimore, Md.

1111 11th Ave.  
Baltimore, Md.

BUREAU V. B.

MAR 29 1955

RECEIVED

With record, Baltimore

With record, Baltimore

6-20-18

Female

INSTRUCTIONS

INSTRUCTIONS  
This form is to be filled out by the local health officer or his representative. It is to be filed in the office of the local health officer and a copy is to be sent to the State Department of Health, Baltimore, Maryland. The form is to be filled out for every death occurring in the community. It is to be filled out for every death occurring in the community. It is to be filled out for every death occurring in the community.

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## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
3199

03173

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>Delmar</u>		<u>7 mo.</u>		TOWN <u>Tyaskin</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Colonial Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MINNIE LEE</u> (First) <u>MESSICK</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Mar.</u> (Day) <u>20</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>widowed</u>	<b>8. DATE OF BIRTH</b> <u>Nov. 28, 1891</u>	<b>9. AGE last birthday</b> <u>63</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>3</u> Days <u>22</u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Corn Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tyaskin, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Wesley Larmore</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Rebecca Garrett</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Florence Messick</u> <u>Princess Line Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.0 IMMEDIATE CAUSE (A)</b> <u>Heart block</u>						<u>15 min.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>arteriosclerotic heart disease</u>						<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>arteriosclerosis generalized</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>senile dementia</u>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>November 14, 1954</u> , to <u>March 20, 1955</u> , that I last saw the deceased alive on <u>March 14, 1955</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>H. V. Sohler</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Delmar Md.</u>		<b>DATE SIGNED</b> <u>3-21-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3/23/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Tyaskin Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Tyaskin, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>3/23/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Harry E. Hudson</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Cornelius S. Messick</u>		<b>ADDRESS</b> <u>Brinkley Md.</u>	

NOTIFICATION

THIS IS TO CERTIFY THAT THE ABOVE NAMED DECEASED WAS A RESIDENT OF THE DISTRICT OF COLUMBIA, AND THAT THE DEATH OF SAID DECEASED WAS REPORTED TO THE DISTRICT OF COLUMBIA HEALTH DEPARTMENT, AND THAT THE DEATH OF SAID DECEASED WAS REGISTERED IN THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH RECORDS.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

8189

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3178  
Item 7, Film 178 3-16-55 et  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03174  
Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Salisbury</u>		<u>life</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>On arrival to Hospital</u>				STREET ADDRESS (If rural, give location) <u>East Rose St.</u>			
3. NAME OF DECEASED: (First) <u>Frank</u>		(Middle) <u>Eugene</u>		(Last) <u>Murray</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Common Law</u>		8. DATE OF BIRTH: <u>About 1887</u>	
9. AGE last birthday: <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		11. BIRTHPLACE (State or foreign country): <u>St. Michaels, Talbot Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>213-14-6246</u>		17. INFORMANT & ADDRESS: <u>Miss Mary Jones, 703 F Rose St. Salisbury, Md.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>213-14-6246</u>		17. INFORMANT & ADDRESS: <u>Miss Mary Jones, 703 F Rose St. Salisbury, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary occlusion</u>						<u>Sudden</u>	
DUE TO							
Antecedent cause(s) (b) <u>Arterio-sclerotic heart disease</u>						<u>Years</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>8</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>3-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-10-50</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Mary A. Stewart</u>		ADDRESS <u>324 E. Church St. Salisbury, Md.</u>	

RECEIVED  
MAR 14 1955  
BUREAU V. S.

On arrival at Hospital  
Unknown  
Informant  
Shore Line  
St. Michael's, Saint Louis, Mo.  
U.S.A.  
Unknown  
215-14-2246  
Mr. J. J. Jones, 215-14-2246  
St. Louis, Mo.

RECEIVED  
MAR 14 1955  
BUREAU V. S.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

3200

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03175

## CERTIFICATE OF DEATH

Dr. Hearne

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>Carey Ave. R.D. # 3</u>				<u>Carey Ave. R.D. # 3</u>		/	
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>OLAF</u>		(Middle) <u>(N/A)</u>		(Last) <u>NELSON</u>		<u>Mar 21 19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Aug. 27, 1878</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Chauffeur</u>		<u>Company Driver</u>		<u>Norway</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Peter Nelson</u>				<u>Elizabeth (Unk)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk</u>				<u>Mrs. Bessie Nelson (Wife) R.D. # 3 Carey Ave. Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Cornary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>Feb 14</u>, 19 <u>55</u>, to <u>March 21</u>, 19 <u>55</u>. That I last saw the deceased alive on <u>March 20</u>, 19 <u>55</u>, and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.</b>							
SIGNATURE <u>Dr. Carrie L. Hearne</u>				DATE SIGNED <u>Mar 21 19 55</u>			
ADDRESS <u>West Church St. Salisbury, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 24, 1955</u>		<u>Mount Hope Cemetery</u>		<u>New York City (Bronx) N.Y.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3/23/55</u>		<u>Mary Holloway</u>		<u>HOLLOWAY &amp; COMPANY</u>		<u>SALISBURY MARYLAND</u>	



1

## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03176

3179

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b> COUNTY <b>Worcester</b>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
12 TOWN <b>Salisbury</b>		3wks.		Berlin		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <b>Peninsula General Hospital</b>				Route # 3			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Lee Purnell</b>				<b>3 - 27 - 19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Male</b>	<b>A. A.</b>	<b>Widowed</b>	<b>3-18-1885</b>	<b>70 yrs.</b>	Months	Days	Hours
						<b>9</b>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Laborer</b>		<b>Berlin Milling Co. Berlin, Worcester Co., Md.</b>		<b>Berlin, Worcester Co., Md.</b>		<b>USA</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>James Purnell</b>				<b>Laura Purnell</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No</b>		<b>No</b>		<b>216-09-5883 Elwood Purnell, Berlin, Md. Rt. # 3</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>151X IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>						<b>NOT KNOWN</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>						<b>4 12</b>	
<b>(B) DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 3/3, 19 55, to 3/27, 19 55 that I last saw the deceased alive on 3/27, 19 55, and that death occurred at M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<b>David J. Purnell M.D.</b>				<b>3/28/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>3-30-55</b>		<b>Evergreen Cemetery</b>		<b>Berlin, Worcester Co., Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<b>March 30, 1955</b>		<b>Mary H. Hallaway</b>		<b>Mary A. Stewart 324 E. Church St Salisbury, Md.</b>			

227-6270

## End Notes

110000

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

02/11/2001

Trade: In 1998, the U.S. exported \$1.1 billion of goods to the Philippines, and imported \$1.1 billion from the Philippines. The U.S. exports to the Philippines include agricultural products, machinery, and transportation equipment. The Philippines exports to the U.S. include agricultural products, minerals, and textiles.

Indice Organico e Funzionale

*E. coli*

1. January

207

8267-97-3

Figure 1

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1.5

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1999

James P. Smith

TAP-00-173

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**BUREAU V. S.**

MAR 30 1955

RECEIVED

22-01-2014

Expenditure

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

3180

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03177

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>WICOMICO</u>		STATE <u>MARYLAND</u>		COUNTY <u>TALBOT</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>12 SALISBURY</u>		<u>4 months</u>		TOWN <u>EASTON</u>		<u>20-40-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91 DEER'S HEAD STATE HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>129 LOCUST STREET</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>BERTHA ADELIA REEVER</u>				<u>3 29 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>8/18/1877</u>	<u>77</u> yrs.	Months Days	Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>HOUSEWIFE</u>		<u>HOUSE WORK</u>		<u>EASTON, MARYLAND</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>MILLARD FILMORE COBURN</u>				<u>MARY VIRGINIA BROWN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>Unk. 91</u>				<u>HOSPITAL RECORDS</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>4200</u> IMMEDIATE CAUSE (A)				<u>CORONARY THROMBOSIS</u>		<u>15 Min.</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerotic heart disease</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
<u>(260x)</u> (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Diabetes mellitus</u>		<u>30 yrs ?</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
<u>---</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Nov. 8, 1954</u>, to <u>Mar. 29, 1955</u>, that I last saw the deceased alive on <u>Mar. 29, 1955</u>, and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. <u>3/30/55</u></b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>M. D. Deer's Head State Hospital; Salisbury, Md.</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>BURIAL</u>		<u>Apr. 1, 1955</u>		<u>SPRING HILL CEMETERY</u>		<u>EASTON, MARYLAND</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>4/1/55</u>		<u>Mary H. Holloway</u>		<u>W. Hampton Caudle</u>		<u>EASTON, MD.</u>	



# CERTIFICATE OF DEATH

3130

DATE OF DEATH

AT WHAT PLACE AND UNDER WHAT CIRCUMSTANCES

HAWAIIAN

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

APR 6 1955

RECEIVED

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03178

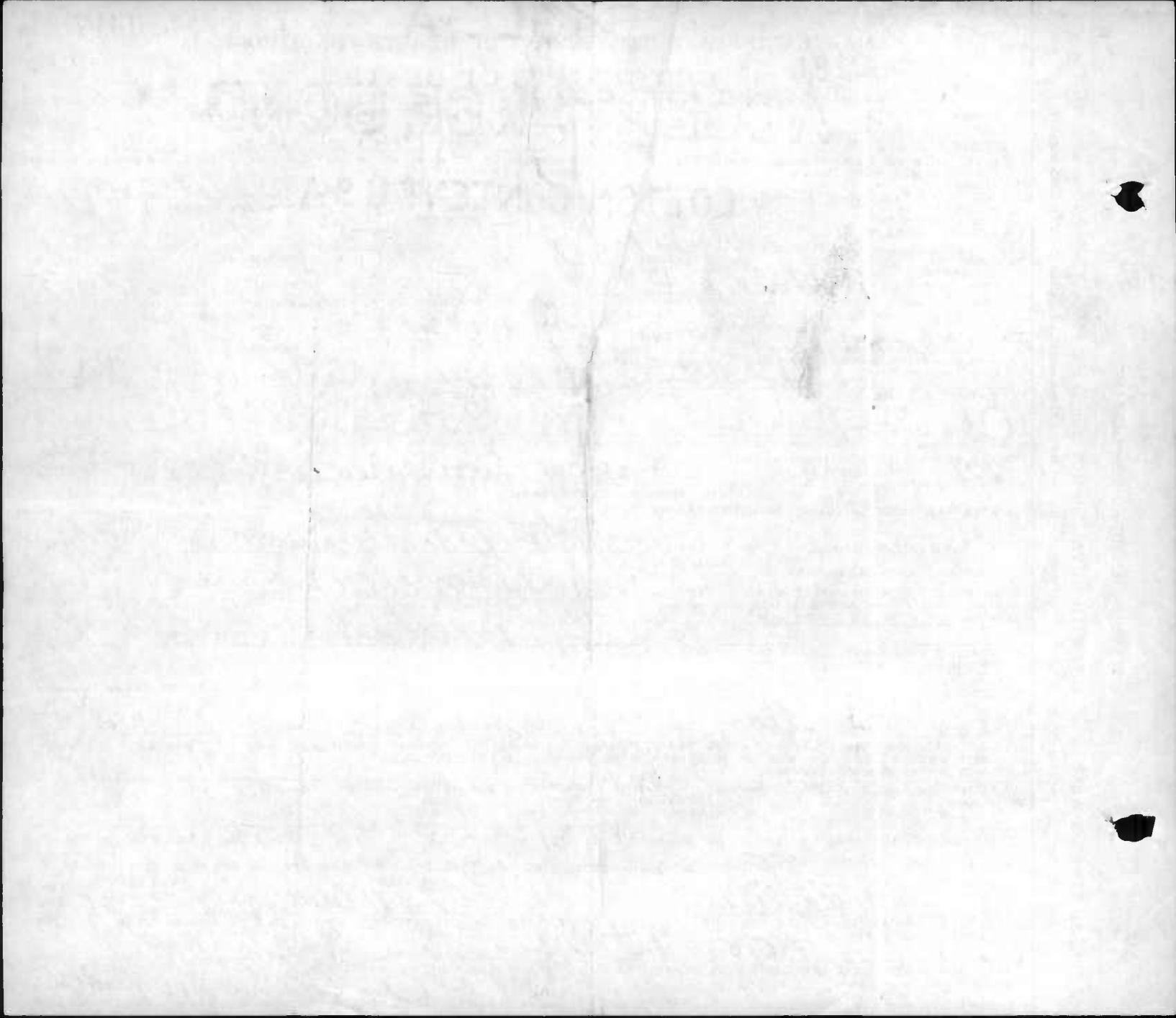
3181

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

Item 7, Film G181, 5/13/55 fcy

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Salisbury</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke City 23-42-2</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>—</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Robbie E. Scott</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>March 30 - 1955</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Jan 4, 1921</i>	9. AGE last birthday: <i>34</i> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <i>maid Restaurant</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): <i>Dummsville Va</i>	
12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>							
13. FATHER'S NAME: <i>Charlie Coles</i>				14. MOTHER'S MAIDEN NAME: <i>Little Vaughan</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>no</i>				16. SOCIAL SECURITY NO.: <i>229-22-0204</i>		17. INFORMANT & ADDRESS: <i>Bolets md. Little Coles 929 Baylis St</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <i>Aspiration Pneumonia</i>				<i>2 hrs</i>			
ANTECEDENT CAUSE (S) (B) <i>Gangrenous ulcer with</i>				<i>"</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Wound abdomen</i>				<i>5-7 days</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>3-24-55</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Gangrenous terminal ileum</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/29, 1955</i> to <i>3/30, 1955</i> , that I last saw the deceased alive on <i>3/30, 1955</i> , and that death occurred at <i>6:35 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>R. H. H. edgick</i>		M. D. <i>2206 Dummsville St</i>		DATE SIGNED <i>3-31-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <i>Burial</i>		DATE THEREOF: <i>4/6/55</i>		NAME OF CEMETERY OR CREMATORY: <i>Mt Auburn Cem</i>		LOCATION (City, town, or county) (State): <i>Balto md</i>	
DATE REC'D BY LOCAL REGISTRAR: <i>4-6-55</i>		REGISTRAR'S SIGNATURE: <i>R. H. H. edgick</i>		24. FUNERAL DIRECTOR: <i>Charles Starke</i>		ADDRESS: <i>512 (and city) av</i>	



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3182

## CERTIFICATE OF DEATH

03179

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		TOWN <u>03-52-2</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 1/2 years</u>		STREET ADDRESS (If rural give location) <u>73 Winters Avenue</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>							
<b>3. NAME OF DECEASED</b> (First) <u>JOHN</u> (Middle) <u>WESLEY</u> (Last) <u>SMITH</u>				<b>4. DATE OF DEATH</b> (Month) <u>3</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/3/1869</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-- --</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-- --</u>		11. BIRTHPLACE (State or foreign country) <u>Cooksville, Md. (Howard Co.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Smith</u>				14. MOTHER'S MAIDEN NAME <u>Fanny Fountain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk. 7</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-12-8428</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>						<u>5 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general and cerebral</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>-- -- 0</u>		19b. MAJOR FINDINGS OF OPERATION <u>-- --</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-- --</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-- --</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-- --</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct. 25, 1951</u> , to <u>Mar. 22, 1955</u> , that I last saw the deceased alive on <u>3/22, 1955</u> , and that death occurred at <u>2:55 A.M.</u> from the causes and on the date stated above. <u>3/22/55</u> <b>SIGNATURE</b> <u>Dr. V. J. Jernigan</u> <b>M.D.</b> <u>Deer's Head State Hospital; Salisbury, Md.</u> <b>ADDRESS</b> (Street, city, town, state) <b>DATE SIGNED</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Western Star</u>		LOCATION (City, town, or county) (State) <u>Baltimore 28, Md.</u>	
24. REC'D BY REGISTRAR <u>3/28/55</u>		REGISTRAR'S SIGNATURE <u>Mary Th. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Holstad</u>		ADDRESS <u>918 Droid Hill Ave</u> <u>Balto Md</u>	

# CERTIFICATE OF DEATH

File No. 100-100000

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and Months)

4. Date of birth (Month, Day, Year)

5. Place of birth (City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Print or write full name)

9. Place of death (City, State, Country)

10. Signature of physician (Print or write full name)

11. Signature of coroner (Print or write full name)

12. Signature of registrar (Print or write full name)

13. Signature of witness (Print or write full name)

14. Signature of witness (Print or write full name)

15. Signature of witness (Print or write full name)

16. Signature of witness (Print or write full name)

17. Signature of witness (Print or write full name)

18. Signature of witness (Print or write full name)

19. Signature of witness (Print or write full name)

20. Signature of witness (Print or write full name)

21. Signature of witness (Print or write full name)

22. Signature of witness (Print or write full name)

23. Signature of witness (Print or write full name)

24. Signature of witness (Print or write full name)

25. Signature of witness (Print or write full name)

26. Signature of witness (Print or write full name)

27. Signature of witness (Print or write full name)

28. Signature of witness (Print or write full name)

29. Signature of witness (Print or write full name)

30. Signature of witness (Print or write full name)

BUREAU V. 2

MAR 28 1955

RECEIVED

EXHIBIT 100-100000

1. Name of deceased (Print or write full name)  
2. Sex (Male or Female)  
3. Age (Years and Months)  
4. Date of birth (Month, Day, Year)  
5. Place of birth (City, State, Country)  
6. Date of death (Month, Day, Year)  
7. Time of death (Hour, Minute)  
8. Cause of death (Print or write full name)  
9. Place of death (City, State, Country)  
10. Signature of physician (Print or write full name)  
11. Signature of coroner (Print or write full name)  
12. Signature of registrar (Print or write full name)  
13. Signature of witness (Print or write full name)  
14. Signature of witness (Print or write full name)  
15. Signature of witness (Print or write full name)  
16. Signature of witness (Print or write full name)  
17. Signature of witness (Print or write full name)  
18. Signature of witness (Print or write full name)  
19. Signature of witness (Print or write full name)  
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24. Signature of witness (Print or write full name)  
25. Signature of witness (Print or write full name)  
26. Signature of witness (Print or write full name)  
27. Signature of witness (Print or write full name)  
28. Signature of witness (Print or write full name)  
29. Signature of witness (Print or write full name)  
30. Signature of witness (Print or write full name)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3183

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

03180

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>12</u> TOWN <u>Salisbury</u>		<u>4</u> hour		TOWN <u>Princess Anne</u> <u>19X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hosp.</u>				STREET ADDRESS (If rural, give location) <u>RFD # 3</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby</u> <u>Boy</u> <u>Spence</u>				<u>3</u> <u>29</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>C</u>	<u>S</u>	<u>3-29-55</u>	<u>0</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Warren Spence</u>				14. MOTHER'S MAIDEN NAME: <u>Madeline Holbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Father* Warren Spence</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<u>1 hr. 40 min.</u>	
<u>776X</u> Immediate cause (a) <u>Prematurity</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>8</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Earl L. Ryan</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-29-55</u>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF <u>2-29-55</u>	NAME OF CEMETERY OR CREMATORY <u>Rome Pot</u>		LOCATION (City, town, or county) (State) <u>Princess Anne, Md.</u>	
DATE REC'D BY LOCAL REG <u>3-29-55</u>	REGISTRAR'S SIGNATURE <u>Marjell H. Hollaway</u>		24. FUNERAL DIRECTOR <u>Warren Spence</u>		ADDRESS <u>Princess Anne, Md.</u>

4135307250

BUREAU V. S.

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## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3184

## CERTIFICATE OF DEATH

03181

33✓

Dr. Gilmore &amp; Ellis

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS <u>231 Hazel Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ELIZABETH CREAMER STEWART</u>				<b>4. DATE OF DEATH</b> (Month) <u>MARCH</u> (Day) <u>6th</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 7, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At own home</u>		11. BIRTHPLACE (State or foreign country) <u>Shad Point Near Salisbury</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W.T. Lewis <del>W.D.</del> Carey</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Gillis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. C. Robert Powell (Daughter) 527 West College Ave. Salisbury, Maryland</u>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.2 IMMEDIATE CAUSE (A) <u>Degenerative heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u></u>							
DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>54</u> , to <u>March 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 6</u> , 1955, and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. R. Ellis, Jr.</u>		M.D. <u>Cemden Ave.</u>		ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>Mar. 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Shad Point Cemetery - Shad Point Md. Near Salisbury, Md</u>		LOCATION (City, town, or county) (State) <u>SALISBURY MARYLAND</u>	
24. REC'D BY REGISTRAR <u>Mar. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

# CERTIFICATE OF DEATH

Form No. 10-1-35

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Immediate cause)

9. Cause of death (Underlying cause)

10. Cause of death (Manner of death)

11. Signature of attending physician

12. Signature of medical examiner

13. Signature of registrar

14. Signature of informant

15. Signature of funeral director

16. Signature of coroner

17. Signature of justice of the peace

18. Signature of health officer

19. Signature of city health officer

20. Signature of county health officer

21. Signature of state health officer

22. Signature of federal health officer

23. Signature of international health officer

24. Signature of other health officer

25. Signature of other official

26. Signature of other official

27. Signature of other official

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BUREAU V. S.

1935

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3185

## CERTIFICATE OF DEATH

03182

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		8 wks.		12 TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>Woodland Rd.</u>				208 W. Locust St.,			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>MARY FLORENCE TAYLOR</u>				<u>3 24 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Oct. 10, 1888</u>	<u>66</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House wife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>J. Wesley Kibble</u>				<u>Annie L. Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>				<u>NONE</u>		<u>Henry S. Taylor 646 Same</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Cardiac arrest</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>myocardial infarction acute</u>						3 Months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Cerebro Vascular accident</u>						3 Months	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/2/53</u> 19 <u>53</u> p. to <u>3/24/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/24/55</u> , 19 <u>55</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>A. C. Mitchell</u>		<u>3/26/1955</u>		<u>Wicomico Mem. Park</u>		<u>Salisbury Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3/28/55</u>		<u>Mary W. Holloway</u>		<u>The Hill &amp; Johnson Co.</u>		<u>Salisbury, Md.</u>	
				<u>Norman Y. Baker</u>			

# CERTIFICATE OF DEATH

2125

Form 1001-10-54

1. NAME OF DECEASED (Print or Type)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DEPUTY SHERIFF

20. SIGNATURE OF CONSTABLE

21. SIGNATURE OF JAILER

22. SIGNATURE OF WARDEN

23. SIGNATURE OF CHIEF OF POLICE

24. SIGNATURE OF DETECTIVE

25. SIGNATURE OF INSPECTOR

26. SIGNATURE OF SUPERVISOR

27. SIGNATURE OF AGENT

28. SIGNATURE OF CLERK

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF DEPUTY SHERIFF

31. SIGNATURE OF CONSTABLE

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35. SIGNATURE OF DETECTIVE

36. SIGNATURE OF INSPECTOR

37. SIGNATURE OF SUPERVISOR

38. SIGNATURE OF AGENT

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80. SIGNATURE OF INSPECTOR

81. SIGNATURE OF SUPERVISOR

82. SIGNATURE OF AGENT

83. SIGNATURE OF CLERK

84. SIGNATURE OF SHERIFF

85. SIGNATURE OF DEPUTY SHERIFF

86. SIGNATURE OF CONSTABLE

87. SIGNATURE OF JAILER

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91. SIGNATURE OF INSPECTOR

92. SIGNATURE OF SUPERVISOR

93. SIGNATURE OF AGENT

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106. SIGNATURE OF SHERIFF

107. SIGNATURE OF DEPUTY SHERIFF

108. SIGNATURE OF CONSTABLE

109. SIGNATURE OF JAILER

110. SIGNATURE OF WARDEN

111. SIGNATURE OF CHIEF OF POLICE

112. SIGNATURE OF DETECTIVE

113. SIGNATURE OF INSPECTOR

114. SIGNATURE OF SUPERVISOR

115. SIGNATURE OF AGENT

116. SIGNATURE OF CLERK

117. SIGNATURE OF SHERIFF

118. SIGNATURE OF DEPUTY SHERIFF

119. SIGNATURE OF CONSTABLE

120. SIGNATURE OF JAILER

121. SIGNATURE OF WARDEN

122. SIGNATURE OF CHIEF OF POLICE

123. SIGNATURE OF DETECTIVE

124. SIGNATURE OF INSPECTOR

125. SIGNATURE OF SUPERVISOR

126. SIGNATURE OF AGENT

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202. SIGNATURE OF SUPERVISOR

203. SIGNATURE OF AGENT

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219. SIGNATURE OF JAILER

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222. SIGNATURE OF DETECTIVE

223. SIGNATURE OF INSPECTOR

224. SIGNATURE OF SUPERVISOR

225. SIGNATURE OF AGENT

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229. SIGNATURE OF CONSTABLE

230. SIGNATURE OF JAILER

231. SIGNATURE OF WARDEN

232. SIGNATURE OF CHIEF OF POLICE

233. SIGNATURE OF DETECTIVE

234. SIGNATURE OF INSPECTOR

235. SIGNATURE OF SUPERVISOR

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237. SIGNATURE OF CLERK

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240. SIGNATURE OF CONSTABLE

241. SIGNATURE OF JAILER

242. SIGNATURE OF WARDEN

243. SIGNATURE OF CHIEF OF POLICE

244. SIGNATURE OF DETECTIVE

245. SIGNATURE OF INSPECTOR

246. SIGNATURE OF SUPERVISOR

247. SIGNATURE OF AGENT

248. SIGNATURE OF CLERK

249. SIGNATURE OF SHERIFF

250. SIGNATURE OF DEPUTY SHERIFF

251. SIGNATURE OF CONSTABLE

252. SIGNATURE OF JAILER

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3201

03183

## CERTIFICATE OF DEATH

Dr. Dunn

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Eden</u>				TOWN <u>Eden</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural give location)			
<u>R.D. # 2</u>		<u>R.D. # 2</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GURNEY</u>		(Middle) <u>WASHINGTON</u>		(Last) <u>TOWNSEND</u>		(Month) <u>MAR.</u> (Day) <u>29</u> (Year) <u>19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 26, 1890</u>	<u>64</u> yrs.	Months <u>8</u>	Days <u>3</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farming</u>		<u>On own Farm</u>		<u>Shad Point, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Elijah Townsend</u>				<u>Emma Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk</u>				<u>Mrs. Josephine B. Townsend (Wife)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr ?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>alcoholic malnutrition; cirrhosis ?</u>				<u>?</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-26, 1952</u> , to <u>3-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-26</u> , 19 <u>55</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Leo M. Hallum M.D.</u>				DATE SIGNED <u>Princess Anne, Md. Mar. 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr. 1, 1955</u>		<u>Shad Point Cemetery</u>		<u>Shad Point Md. Near Salisbury Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3/31/55</u>		<u>Mary H. Holloway</u>		<u>HOLLOWAY &amp; COMPANY</u>		<u>SALISBURY MARYLAND</u>	





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3186

03184

## CERTIFICATE OF DEATH

Dr. Ellis

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>304 Elzy Place</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>MARY ELIZABETH TOWNSEND</u>				<u>MAR 20 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>March 29, 1889</u>	<u>65</u> yrs.	Months <u>11</u> Days <u>21</u>	Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Work</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Allen Maryland Wicomico Co.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William Goslee</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anrillia Murray</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
				<u>Mr. Curtis B. Townsend (Husband) 304 Elzy Place, Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>260X IMMEDIATE CAUSE (A)</b> <u>Myocardial Infarct, Acute</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 hours</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<u>Diabetes mellitus</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<u>Cholelithiasis</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>2</u>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>3-20, 19 55</u> , <b>to</b> <u>3-20, 19 55</u> , <b>that I last saw the deceased alive on</b> <u>3-20, 19 55</u> , <b>and that death occurred at</b> <u>1:25 P.</u> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>William R. Ellis, Jr.</u>				<b>DATE SIGNED</b> <u>Mar. 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>ADDRESS</b> (Street, city, town, state)			
<b>DATE THEREOF</b> <u>Mar. 23, 1955</u>				<b>LOCATION</b> (City, town, or county) (State)			
<b>24. REC'D BY REGISTRAR</b> <u>Mary Holloway</u>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</u>			
<b>DATE</b> <u>3/23/54</u>				<b>ADDRESS</b>			

# CERTIFICATE OF DEATH

Form 100-100-100

A. DEATH INFORMATION

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ADDITIONAL INFORMATION

U.S. FORM NO. 100-100-100

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

BUREAU V. S.

MAR 23 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

3187

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03185

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Thurmont</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		<u>23X-2</u>	
TOWN <u>St. Michaels</u>				STREET ADDRESS (if rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P. G. Hospital</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Lucy P. Tull</u>				<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 9-1886</u>	9. AGE last birthday <u>68</u> <u>9/9</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>9</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Parsonsburg, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Daniel Perdue</u>				14. MOTHER'S MAIDEN NAME <u>Alma White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Mrs. Wilbur Rowley, Snow Hill, md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-17</u> , 19 <u>55</u> , to <u>3-18</u> , 19 <u>55</u> that I last saw the deceased alive on <u>3-18</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles E. Ellis, Jr.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>3-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 29, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Bowen</u>		LOCATION (City, town, or county) (State) <u>Newark, md</u>	
24. REC'D BY REGISTRAR <u>MAK 5-1-55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Harris</u>		ADDRESS <u>Snow Hill, md</u>	
DATE							

# CERTIFICATE OF DEATH

Age, Date, Sex

2. USUAL RESIDENCE HOME OR DECEASED

3. PLACE OF DEATH

MARYLAND

COUNTY

DATE  
OF  
DEATH

DATE  
OF  
DEATH

10. MEDICAL CERTIFICATION

1. NAME OF PHYSICIAN (PRINT NAME AND ADDRESS)

BUREAU V. S.

MAR 21 1955

RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3188

03186

Reg. Dist. No. 332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>DEL.</u>		COUNTY <u>SUSSEX</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>12</u> <u>SALISBURY</u>		<u>4 months</u>		TOWN <u>MILTON</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williams St.</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>LUTHER</u>		(Middle)		(Last) <u>VEASEY</u>		3 29 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>Sept. 26, 1880</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMER</u>		<u>SELF -</u>		<u>Delaware</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>UNKNOWN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>None</u>		<u>daughter: Mrs. Donaway, Wm. St.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause			(a) <u>Coronary Occlusion</u>				<u>year</u>
Antecedent cause(s)			DUE TO <u>Arterio-sclerotic C.V. Disease</u>				
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			DUE TO				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Ryan</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-29-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/31/55</u>		<u>BEAVERDAM CEMETERY</u>		<u>HABERSON, DELAWARE</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-29-55</u>		<u>Marjell Holloway</u>		<u>The Hill + Johnson Co</u>		<u>SALISBURY, MD</u>	
<u>Norman T. Baker</u>							

BUREAU V. S.

APR 1 1955

RECEIVED



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## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3202

## CERTIFICATE OF DEATH

03187

33 ✓

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Fruitland</b>		<b>Most of life</b>		TOWN <b>Fruitland</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>At home - S. Division St. ext.</b>				STREET ADDRESS (If rural give location) <b>S. Division St. ext.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Gladys</b> (Middle) <b>Morris</b> (Last) <b>Waples</b>				(Month) <b>3</b> (Day) <b>3</b> (Year) <b>19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<b>Female</b>	<b>A.A.</b>	<b>Divorced</b>	<b>3-18-1916</b>	<b>38 yrs.</b>	Months <b>11</b> Days <b>15</b>	Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Laborer</b>		<b>Kid Factory</b>		<b>Fruitland, Wicomico Co. Md.</b>		<b>USA</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Sidney Morris</b>				<b>Rachel Jane Allen</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No</b>		<b>No</b>		<b>Mrs. Effie Pitts, Fruitland, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>331X</b>				<b>IMMEDIATE CAUSE (A)</b>		<b>1 yr</b>	
				<b>ANCECEDENT CAUSE(S) DUE TO</b>			
				<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>			
				<b>STATING UNDERLYING CAUSE LAST.</b>			
				<b>(C)</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>0</b>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 19 54, to Feb 9 55, that I last saw the deceased alive on 3-3-55, and that death occurred at 9 55 M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>DATE SIGNED</b>	
<b>Lee L Lawry</b>		<b>3-7-55</b>		<b>Mt. Calvary Cemetery</b>		<b>3-4-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<b>Burial</b>		<b>3-7-55</b>		<b>Mt. Calvary Cemetery</b>		<b>Fruitland, Wicomico Co. Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>Mar. 7, 1955</b>		<b>Mary H. Holloway</b>		<b>Mary A. Stewart</b>		<b>324 E. Church St. Salis. Md.</b>	

# CERTIFICATE OF DEATH

8208

Reg. Dist. No.

1. Usual Residence of Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Manner of Death

6. Age at Death

7. Sex

8. Race

9. Marital Status

10. Occupation

11. Education

12. Date of Birth

13. Date of Death

14. Date of Burial

15. Place of Burial

16. Name of Burial Place

17. Name of Minister

18. Name of Physician

19. Name of Coroner

20. Name of Registrar

21. Name of Clerk

22. Name of Assistant Registrar

23. Name of Assistant Clerk

24. Name of Assistant Coroner

25. Name of Assistant Minister

26. Name of Assistant Physician

27. Name of Assistant Coroner

28. Name of Assistant Registrar

29. Name of Assistant Clerk

30. Name of Assistant Assistant Registrar

31. Name of Assistant Assistant Clerk

32. Name of Assistant Assistant Coroner

33. Name of Assistant Assistant Minister

34. Name of Assistant Assistant Physician

35. Name of Assistant Assistant Coroner

36. Name of Assistant Assistant Registrar

37. Name of Assistant Assistant Clerk

38. Name of Assistant Assistant Assistant Registrar

39. Name of Assistant Assistant Assistant Clerk

40. Name of Assistant Assistant Assistant Coroner

41. Name of Assistant Assistant Assistant Minister

42. Name of Assistant Assistant Assistant Physician

43. Name of Assistant Assistant Assistant Coroner

44. Name of Assistant Assistant Assistant Registrar

45. Name of Assistant Assistant Assistant Clerk

46. Name of Assistant Assistant Assistant Assistant Registrar

47. Name of Assistant Assistant Assistant Assistant Clerk

48. Name of Assistant Assistant Assistant Assistant Coroner

49. Name of Assistant Assistant Assistant Assistant Minister

50. Name of Assistant Assistant Assistant Assistant Physician

51. Name of Assistant Assistant Assistant Assistant Coroner

52. Name of Assistant Assistant Assistant Assistant Registrar

53. Name of Assistant Assistant Assistant Assistant Clerk

54. Name of Assistant Assistant Assistant Assistant Assistant Registrar

55. Name of Assistant Assistant Assistant Assistant Assistant Clerk

56. Name of Assistant Assistant Assistant Assistant Assistant Coroner

57. Name of Assistant Assistant Assistant Assistant Assistant Minister

58. Name of Assistant Assistant Assistant Assistant Assistant Physician

59. Name of Assistant Assistant Assistant Assistant Assistant Coroner

60. Name of Assistant Assistant Assistant Assistant Assistant Registrar

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62. Name of Assistant Assistant Assistant Assistant Assistant Assistant Registrar

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64. Name of Assistant Assistant Assistant Assistant Assistant Assistant Coroner

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71. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Clerk

72. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Coroner

73. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Minister

74. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Physician

75. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Coroner

76. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Registrar

77. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Clerk

78. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Assistant Registrar

79. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Assistant Clerk

80. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Assistant Coroner

81. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Assistant Minister

82. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Assistant Physician

83. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Assistant Coroner

84. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Assistant Registrar

85. Name of Assistant Assistant Assistant Assistant Assistant Assistant Assistant Assistant Clerk

BUREAU V. S.

MAR 7 1955

RECEIVED

1. Usual Residence of Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Manner of Death

6. Age at Death

7. Sex

8. Race

9. Marital Status

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3203

## CERTIFICATE OF DEATH

03188

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>rural: Allen</u>		LENGTH OF STAY (In this place) <u>most of life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural: Allen</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 <u>at home - Upper Ferry Road</u>				STREET ADDRESS (If rural give location) <u>upper Ferry Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>John Wesley Waters</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 20 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>about 1873</u>	9. AGE last birthday <u>about 82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Allen, Wicomico Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Waters</u>				14. MOTHER'S MAIDEN NAME <u>Mary Anne Brewington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S ADDRESS <u>Mrs. Sarah E. Waters 2022 N. 17<sup>th</sup> St. Phila. Pa.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 10, 1955</u> , to <u>March 20, 1955</u> , that I last saw the deceased alive on <u>March 20, 1955</u> , and that death occurred at <u>home</u> from the causes and on the date stated above.							
SIGNATURE <u>Kendrick McCullough, M.D.</u>		ADDRESS (Street, city, town, state) <u>Parsonage Rd Salisbury, Maryland</u>		DATE SIGNED <u>March 20, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		LOCATION (City, town, or county) (State) <u>Allen, Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR <u>3/28/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary E. Stewart</u>		ADDRESS <u>324 E. Church Street Salisbury, Maryland</u>	

BUREAU V. S.

1954 00 1054

RECEIVED

1

## INSTRUCTIONS

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3189

03189

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>20</u> years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82</u> <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>905 East Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Lillian Mae Waters</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>3</u> - <u>9</u> - <u>1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>A.A.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>5-10-1898</u>	<b>9. AGE last birthday</b> <u>56</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>9</u> Days <u>29</u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Public School</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Bridgeville, Sussex Co. Del.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Julian Hargis Dredden</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Janie Phoebe Cornish</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Paul Waters, 905 East Rd. Salisbury, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>1</b> IMMEDIATE CAUSE (A) <u>260X</u> <u>Arteriosclerosis</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>1/14</u> <u>1955</u> , <b>to</b> <u>3/9</u> <u>1955</u> , <b>that I last saw the deceased alive on</b> <u>3/9</u> <u>1955</u> , <b>and that death occurred at</b> <u>9:20 A.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Andrew C. Mitchell</u>		<b>DATE THEREOF</b> <u>3-13-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Concord Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Concord, Sussex Co., Del.</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REG'D BY REGISTRAR</b> <u>March 14, 1955</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Mary A. Stewart</u>		<b>ADDRESS</b> <u>324 E. Church St. Salisbury, Maryland</u>	



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# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 60		4. DATE OF DEATH 10-10-1965	
5. PLACE OF DEATH Baltimore, Maryland		6. COUNTY Baltimore		7. STATE Maryland		8. ZIP CODE 21201	
9. NAME OF PHYSICIAN JAMES H. HARRIS		10. NAME OF HOSPITAL JAMES H. HARRIS		11. NAME OF NURSING HOME JAMES H. HARRIS		12. NAME OF OTHER FACILITY JAMES H. HARRIS	
13. NAME OF FUNERAL HOME JAMES H. HARRIS		14. NAME OF CEMETERY JAMES H. HARRIS		15. NAME OF BURIAL PLACE JAMES H. HARRIS		16. NAME OF OTHER PLACE JAMES H. HARRIS	
17. NAME OF NEXT OF KIN JAMES H. HARRIS		18. NAME OF SURVIVOR JAMES H. HARRIS		19. NAME OF OTHER PERSON JAMES H. HARRIS		20. NAME OF OTHER PERSON JAMES H. HARRIS	
21. NAME OF OTHER PERSON JAMES H. HARRIS		22. NAME OF OTHER PERSON JAMES H. HARRIS		23. NAME OF OTHER PERSON JAMES H. HARRIS		24. NAME OF OTHER PERSON JAMES H. HARRIS	
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BUREAU V. 2

RECEIVED

MAR 14 1965



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03190

Dr. Lewis 3204

## CERTIFICATE OF DEATH

Reg. Dist. No. 33✓

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>in Village</u>				STREET ADDRESS (If rural give location) <u>In Village</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>ANNIE J. WATSON</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 2nd 1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 31, 1893</u>		<b>9. AGE last birthday</b> <u>61</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>6</u> Days <u>1</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Work</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pittsville, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Parsons</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Parker</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Miss Beatrice Watson (Daughter)</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>331X</u> IMMEDIATE CAUSE (A) <u>cerebral hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>				<b>18. MEDICAL CERTIFICATION</b> <u>Pittsville, Maryland</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH?</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <u>3-2</u> M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>2-25</u> , 19 <u>55</u> , to <u>3-2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>55</u> , and that death occurred at <u>3:15 A.</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Frank Lewis</u>				<b>DATE SIGNED</b> <u>Willards Maryland Mar. 3 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Mar. 5, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Farlow Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Near Pittsville, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Mar. 7, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
Item 17: Form 100 4-15-55				No. 332			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Fruitland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural, give location) <u>None</u>		/	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>OLIVER G. WILLEY</u>				<u>MAR 29 th 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Mar. 18, 1894</u>	
9. AGE last birthday: <u>61</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>On Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Somerset Co. Maryland Eden.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>On Farm</u>			
13. FATHER'S NAME: <u>John Willey</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Ella Knox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Uak</u>				16. SOCIAL SECURITY NO.: <u>9</u>			
17. INFORMANT & ADDRESS: <u>Virgie Mrs. Virgie Culver (Sister) Fruitland Maryland</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>35 minutes</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>023X</u>							
Immediate cause (a) <u>Acute congestive heart failure</u>							
DUE TO <u>Lucetic Pontitis</u>							
Antecedent cause(s) (b) <u>giving rise to the above cause</u>							
DUE TO <u>stating underlying cause last</u>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Roy</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Mar. 30 1955</u>			
M. D. <u>Walter R. Holloway</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>April 2, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Allen Cemetery</u>		LOCATION (City, town, or county) (State): <u>Allen, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3-31-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS: <u>SALISBURY MARYLAND</u>	
Walter R. Holloway							

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 03192  
 Reg. Dist.

No. 332

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Salisbury-Walston</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Salisbury (Rural) Walston</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>R.D. # 3</u>				STREET ADDRESS (If rural, give location) <u>R.D. # 3</u>			
3. NAME OF DECEASED: (First) <u>IRA</u>		(Middle) <u>CLYDE</u>		(Last) <u>WORKMAN</u>		4. DATE OF DEATH (Month) <u>MAR</u> (Day) <u>12</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug 25, 1907</u>		9. AGE last birthday: <u>47</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>House Construction</u>		11. BIRTHPLACE (State or foreign country): <u>R.D. Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>King W. Workman</u>				14. MOTHER'S MAIDEN NAME: <u>Martha A. Brittingham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Mildred Workman (Wife) R.D. # 3 Salisbury</u>			
<b>18. MEDICAL CERTIFICATION</b> <u>Maryland</u>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Bullet wound of Brain</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO stating underlying cause last (c)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u> )		21c. (City or town) <u>Walston</u> (County) <u>Wicomico</u> (State) <u>MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3 12 55 6:45 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Self-inflicted Rifle wound</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Emil L. Royer</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Mar. 14 1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Mar. 16 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>R.D. # Salisbury, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3-16-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

Walter R. Holloway

BUREAU V. S.

MAR 18, 1955

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## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Tyaskin</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
82 <u>Peninsula General Hospital</u>				<u>Box 89</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Wright</u>				<u>March 15</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<u>male</u>	<u>col</u>		<u>March 15-1915</u>				<u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
				<u>Gloria Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Y</u>				<u>Gloria Wright, Tyaskin Md. Box 89</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Morris G. Lambdin</u>				<u>Camden Ave. Salisbury Md</u>		<u>3-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>3-16-55</u>		<u>Peninsula General Hospital</u>		<u>Salisbury, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3-16-55</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>			

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